TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-26

2. STATE: ILLINOIS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 02 $0
b. FFY 03 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Appendix to Attachment 3.1-A Pages 1, 1(A), 1(A)(1), 1(A)(2), 1(A)(3), 1(A)(4), 1(A)(5), 1(A)(6), 1(A)(7), 1(A)(9)
Attachment 4-19B pages 2, 14, 15, and 17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Appendix to Attachment 3.1-A Pages 1, 1(A), 1(A)(1), 1(A)(2), 1(A)(3), 1(A)(4), 1(A)(5), 1(A)(6), 1(A)(7), 1(A)(9)
Attachment 4-19B pages 2,14, 15, and 17

10. SUBJECT OF AMENDMENT:

Outpatient Services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:

13. TYPED NAME: **Jackie Garner**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 10/1/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
AUG 1 0 2002
DMCH - IL/IN/OH

FORM HCFA-179 (07-92)

Instructions on Back

State Illinois

1. INPATIENT HOSPITAL SERVICES (OTHER THAN THOSE PROVIDED IN AN INSTITUTION FOR MENTAL DISEASES OR TUBERCULOSIS)

- Certain inpatient hospital services are subject to review by the Department's Peer Review Organization and will not be covered unless medical necessity is shown and documented. At least thirty days prior to the effective date, hospitals are notified of changes to review requirements. Statewide hospital review requirements are specified in the Department's provider manuals and/or notices.
- Preoperative days will be limited to only the day immediately preceding surgery unless the attending physician provides documentation demonstrating the medical necessity of an additional day or days.
- Inpatient psychiatric services are subject to a review by the Department's Peer Review Organization. Only medically necessary inpatient psychiatric care will be approved.
- Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under ~~age~~ 21 years of age.

2. OUTPATIENT HOSPITAL SERVICES

Most outpatient hospital services provided are covered utilizing specific fee-for-service codes. Utilization control, e.g., prior approval policies which may apply to the service in question and which would be required of nonhospital providers rendering services on a fee-for-service basis, is in effect.

7/02 ~~A Hospital Ambulatory Care~~ The Ambulatory Procedure Listing ~~list~~ defines those technical procedures that routinely require the use of the hospital outpatient setting, its technical staff and/or equipment. This list is updated annually.

Client coverage policies applicable to those services provided under the policy used by nonhospital providers include any requirements for utilization control or prior approval as specified in the Illinois Administrative Code ~~Rule~~ and Provider Handbooks.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under ~~age~~ 21 years of age.

TN # 02-26
SUPERCEDES
TN # 01-05

APPROVAL DATE ~~OCT~~ 01 2002 Effective Date 7/01/02

State Illinois

The following definitions apply to the provision of hospital outpatient and clinic services in Section 4.19-B of this State plan::

=7/95 1. "Certified Hospital Ambulatory Primary Care Center (CHAPCC)" means a Maternal and Child Health (MCH) clinic which meets the participation, data and certification requirements described in this Section, that is hospital-based and which, through staff and supporting resources, provides ambulatory primary care to Medicaid children from birth through 20 years of age and pregnant women in a non-emergency room setting. At least 50% of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50% of patient visits to the CHAPCC must be for primary care.

2. "Certified Hospital Organized Satellite Clinic" ~~(CHOSC)"~~ means a Maternal and Child Health clinic that meets the participation, data and certification requirements described in this Section that is owned, operated, ~~and/~~or managed by a hospital but does not qualify as a hospital-based clinic because it is not located adjacent to or on the premises of the hospital or is not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency room setting to Medicaid children from birth through 20 years of age and to pregnant women. At least 50% of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50% of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized expertise necessary for the provision of secondary and tertiary care.

3. "Certified Obstetrical Ambulatory Care Center" ~~(COBACC)"~~ means a Maternal and Child Health clinic that meets the participation, data and certification requirements described in this Section and which, through staff and supporting resources, provides primary care and specialty services to Medicaid-eligible pregnant women especially those determined to be non-compliant or at high risk, in an outpatient setting.

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=7/95 4. "Certified Pediatric Ambulatory Care Center" ~~(CPACC)"~~ means a Maternal and Child Health clinic that meets the participation, data and certification requirements described in this Section that qualifies as a hospital-based clinic and that, through staff and supporting resources, provides pediatric primary care and specialty services to Medicaid children with specialty needs from birth through 20 years of age in an outpatient setting. Hospitals with CPACC's must also provide primary care for at least 1,500 children not eligible for enrollment in the CPACC, as part of a CHAPCC, a CHOSC or an encounter rate clinic. Hospitals unable to meet this volume requirement must agree to serve as a specialty referral site for another hospital operating a CPACC through a written agreement submitted to the Department.

04/93 5. "Children's hospital" means a hospital that is engaged in furnishing services to outpatients who are predominately individuals under 18 years of age.

7/02 6. "Encounter" ~~rate hospital~~ means a face-to-face visit with a physician, nurse midwife, nurse practitioner or physician supervised physician assistant. Reimbursement for such encounters includes all medically-necessary services and supplies furnished by or under the direction of a physician within the scope of their licensed practice. Some examples of these services include:

a) medical case management;
b) laboratory services;
c) occupational therapy;
d) patient transportation;
e) pharmacy services;
f) physical therapy;
g) podiatric services
h) optometric services;
i) speech/hearing services;
j) x-ray services;
k) health education;
l) nutrition services.

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7/02 ~~a. Illinois county-owned hospitals located in a county with a population exceeding 3 million that has provided and that has been paid for less than 85,000 days of inpatient hospital care to recipients of medical assistance during State Fiscal Year 1989; or~~

~~b. Illinois county-owned hospitals located in a county with a population exceeding 3 million that has provided and that has been paid for 85,000 days or more of inpatient hospital care to recipients of medical assistance during State Fiscal Year 1989; or~~

~~c. Illinois state-owned hospitals located in a county with a population exceeding 3 million; or~~

~~d. Illinois county-operated outpatient facilities in a county with a population exceeding 3 million.~~

04/93 7. "General clinic" means a hospital-based clinic that provides diagnostic, therapeutic and palliative services provided under the direction of a physician who provides for the health care needs of persons who elect to use this type of service rather than another source of primary care, and is enrolled with the Department for the provision of general clinic services (category of service 26).

=7/02 8. "Maternal and Child Health Clinics" means a clinic providing medical care to pregnant women ~~and/~~or children from birth through 20 years of age.

a. The following outpatient clinics are recognized as a primary care provider to MCH clients:

i. Certified Hospital Ambulatory Primary Care Center (CHAPCCs);

ii. Certified Hospital Organized Satellite Clinics (CHOSCs);

iii. Certified Obstetrical Ambulatory Care Centers (COBACCs); and

iv. Certified Pediatric Ambulatory Care Centers (CPACCs).

=7/95 b. General Participation Requirements. In addition to the Maternal and Child Health provider participation requirements described in this Section of the plan, the Maternal and Child Health clinics identified above must:

i. Be operated by a disproportionate share hospital, as described in Attachment 4.19-A, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 pregnant women and children; or be a primary care teaching site of an organized academic department of:

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A. In the case of CHAPCC and a CHOSC, a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accreditation;

B. In the case of a COBACC, an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accreditation, with at least 130 full-time equivalent residents;

C. In the case of a CPACC, a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accreditation, with at least 130 full-time equivalent residents.

iii. Under the direction of a board certified/eligible physician who has hospital admitting ~~and/~~or delivery privileges and provides direct supervision to residents practicing in the Certified ambulatory site, provide:

A. In the case of a Certified Hospital Ambulatory Primary Care Center and a Certified Hospital Organized Satellite Clinic, primary care.

B. In the case of a Certified Obstetrical Ambulatory Care Center, obstetric and specialty services.

C. In the case of a Certified Pediatric Ambulatory Care Center, primary care and specialty services.

iv. Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation of Health Care Organizations;

v. Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department;

vi. Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality;

vii. Submit patient level historical data to the Department, in a manner and format specified by the Department which may include, but shall not be limited to, historical data on the use of the hospital emergency room department; and

viii. Be certified annually during the first two years of participation and every other year thereafter. In addition:

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A) the certification process shall consist of a review of the completed application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on-site by Department staff within 60 days of application approval. Final notification of certification status shall be rendered within 30 days of the site review, pending provider submittal of a written plan of correction for any deficiencies discovered during the entire application process; and

B) certification status shall be suspended for Maternal and Child Health clinics that do not submit data to the Department within 180 days of the Department's request for the submittal of such data.

=7/95 c. Special Participation Requirements. In addition to the Maternal and Child Health provider participation requirements described in this section of the plan and the general participation requirements described above, special participation requirements shall apply as follows:

i. Certified Hospital Ambulatory Primary Care Centers ~~(CHAPCCs)~~ and Certified Hospital Organized Satellite Clinics ~~(CHOSCs)~~ must:

A. Serve a total population that includes at least 20% Medicaid and medically indigent clients;

B. Perform a risk assessment on pregnant women in order to determine if the woman is at high risk; and

C. Provide or arrange for specialty services when needed by pregnant women or children.

ii. Certified Obstetrical Ambulatory Care Centers (~~COBACC's~~) must:

A. Be a distinct department of a hospital that also operates as a Level II or Level III perinatal center;

B. Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to each Medicaid and Medicaid-eligible woman who receives services at the COBACC;

C. Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;

D. Have an established program of services for the treatment of substance-abusing pregnant women;

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E. Integrate an accredited obstetrical residency program with subspecialty residence programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and

F. Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.

iii. Certified Pediatric Ambulatory Care Centers ~~(CPACCs)~~ must:

A. Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition.

B. Operate a designated 24-hour per day emergency referral site with a defined practice for the care of pediatric emergencies;

C. Provide access to necessary pediatric primary and specialty services within 24 hours of referral;

D. Be a distinct department of a disproportionate share hospital, as described in Attachment 4.19-A;

E. Integrate an accredited pediatric or family practice residence program with subspecialty residence programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty care needs; and

F. Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.

=7/02 d. Covered Services. The following services will be considered as covered by Maternal and Child Health clinics when provided by, or under the direction, of a physician:

i. In the case of CHAPCCs and CHOSCs, primary care services ~~delivered by a CHAPCC which~~ must include but ~~may~~ are not necessarily be limited to:

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A. Early, periodic, screening, diagnostic, and treatment (EPSDT) services;

B. Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;

C. Regular immunizations for the prevention of childhood diseases;

D. Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;

E. Routine prenatal care, including risk assessment, for pregnant women; and

F. Specialty care as medically necessary.

7/02 ii. In the case of Certified Obstetrical Ambulatory Care Centers ~~(COBACC's),~~ primary care and specialty services ~~delivered by a COBACC which~~ must include, but ~~may~~ are not necessarily be limited to:

A. Prenatal care, including risk assessment (one risk assessment per pregnancy);

B. All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and

C. Services to pregnant women with diagnosed substance abuse or addiction problems.

7/02 iii. In the case of Certified Pediatric Ambulatory Care Centers ~~(CPACC's):~~

A. Comprehensive medical and referral services.

B. Primary care services delivered by a CPACC which must include, but may not necessarily be limited to:

1) Early, periodic, screening, diagnostic, and treatment (EPSDT services;

2) Regular immunizations for the prevention of childhood diseases; and

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3) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.

C. Pediatric specialty services which must include, at a minimum, necessary treatment for:

1) Asthma;

2) Congenital heart disease;

3) Diabetes; and

4) Sickle cell anemia.

D. Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.

07/02 9. "Hospital" means:

a) For the purpose of hospital outpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of hospital outpatient reimbursement, the term "hospital" shall also include the following facilities located in an Illinois county with a population of over three million:

1) County-owned hospitals; or

==07/02 2) ~~A hospital organized under the University of Illinois Hospital Act~~ State-owned hospitals; or

==07/95 3) County-operated outpatient facilities located in the State of Illinois.

b) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

07/02 12. "Psychiatric clinic" means a hospital-based clinic that is enrolled with the Department to provide:

a. Psychiatric Clinic Services (Type A). Type A psychiatric clinic services (category of service/ 27) are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting for individuals through ~~the age of twenty-one (21).~~ 21 years of age.

b. Psychiatric Clinic Services (Type B). Type B psychiatric clinic services (category of service/ 28) are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four (4) hours per day at a minimum of three (3) half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six (6) months in any twelve (12) month period.

04/93 13. "Physical rehabilitation clinic" means a hospital-based clinic that provides rehabilitative services and is enrolled with the Department for the provision of physical rehabilitation clinic services (category of service/ 29). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.

07/02 14. County-owned hospital means all county-owned hospitals that are located in an Illinois county with a population of over three million.

07/02 15. County-operated outpatient facility means a clinic (e.g., CPACC,CHAPCC, CHOSC or an encounter rate clinic), health center, or other facility, operated by an Illinois county that has a population exceeding three million persons, other than a hospital outpatient department or a pharmacy, that provides ambulatory services on an encounter basis.

07/02 16. State-owned hospital means a hospital organized under the University of Illinois Hospital Act.

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SUPERCEDES

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

04/93 iii. With respect to Illinois county-owned encounter rate hospitals as defined in Appendix to Attachment 3.1-A ~~and 3.1-B,~~ the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

04/93 A. The reimbursement rates described above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

7/95 iv. Enhanced rates as described in the annual obstetric and pediatric State plan shall be paid to CHAPCCs, CHOSCs, COBACCs and CPACCs. The enhanced rates are effective for services provided in MCH clinics on or after April 1, I993.

07/93 v. County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

07/93 vi. With the exception of the retrospective adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section.

07/02 b. Ambulatory Procedure Listing (APL)

Effective July 1, 1998, the Department will reimburse hospitals, for certain hospital outpatient procedures as described in b.1. of this Section

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

07/95 c. Payment for outpatient end-stage renal disease treatment (ESRDT) services shall be:

07/95 i. At the rate established by Medicare pursuant to 42 CFR 405, Subpart U (1994).

07/02 ii. With respect to Illinois county-owned ~~encounter rate~~ hospitals, as defined in Appendix to Attachment 3.1A, the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

07/95 A. The reimbursement rates described in this section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

07/02 iii. With the exception of the retrospective rate adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1 c.

07/95 iv. County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

TN # 02-26 APPROVAL DATE OCT 01 2002 EFFECTIVE DATE 07-01-02

Supersedes

TN # 98-14

State Illinois

07/93 d. Non Hospital-Based Clinic Reimbursement

i. County-Operated Outpatient Facility Reimbursement

07/02 For ~~those encounter rate hospitals described as Illinois~~ county-operated outpatient facilities as defined in Appendix to Attachment 3.1-A, ~~in a county with a population exceeding 3 million~~ that do not qualify as either a Maternal and Child Health Program, managed care clinic, or as a Critical Clinic Provider, as described in subsection e. below, reimbursement for all services ~~provided by county-operated outpatient facilities~~ shall be ~~reimbursed~~ on an all-inclusive per encounter rate basis, determined as follows:

A. Base Rate

The per encounter base rate shall be calculated as follows:

1. Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

07/95 2. The resulting quotient, as calculated in 1. above shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

3. The resulting product as calculated in 2. above shall be added to the resulting quotient, as calculated in 1. above to determine the per encounter base rate.

07/95 B. Supplemental Rate

1. The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

07/95 2. The direct supplemental service cost, as calculated in 1. above, shall be multiplied by the Medicare allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

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SUPERSEDES

TN # 98-14

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

07/02 ii. County-operated outpatient facilities shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year. No year-end reconciliation for ~~outpatient and clinic services~~ is made to the reimbursement calculated under this section.

07/02 iii. Services are available to all clients in geographic areas in which an ~~encounter rate~~ county-owned hospital or a county-operated outpatient facility is located.

09/97 e. Critical Clinic Providers

i. Effective for services provided on or after September 27, 1997, clinics owned and operated by a county with a population of over three million, that are within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection .e. requires that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:

A. 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,

B. 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,

C. 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,

D. 3600 for reimbursement provided during the facility's cost reporting year ending during 2001,

E. 4200 for reimbursement provided during the facility's cost reporting year ending during 2002,

ii. Reimbursement for all services provided by a Critical Clinic Provider shall be on an all-inclusive per encounter rate which shall equal reported direct costs of the Critical Clinic Provider for the facility's cost reporting period ending in 1995, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.